



CERTIFICATE OF IMMUNIZATION
NORTH DAKOTA DEPARTMENT OF HEALTH
 SFN 16038 (Revised 01-2018)

Division of Disease Control
 2635 East Main Ave. PO Box 5520
 Bismarck, ND 58506-5520
 800.472.2180 or 701.328.3386

Child's Name (Last, First, Middle Initial):	Date of Birth:
Parent's Name:	Telephone Number:

Vaccine Type		Exemption Type*	Enter Month/Day/Year for Each Immunization Given				
Hepatitis B	Hepatitis B						
Rotavirus	Rotavirus						
Hib	<i>Haemophilus influenzae</i> type B						
PCV	Pneumococcal conjugate						
DTP/DTaP/DT	Diphtheria-Tetanus-Pertussis						
IPV/OPV	Polio						
MMR	Measles-Mumps-Rubella						
Varicella	Chickenpox						
Hepatitis A	Hepatitis A						
Td/Tdap	Tetanus-Diphtheria (and Pertussis)						
MCV4	Meningococcal ACYW-135						
HPV	Human Papillomavirus						
Men B	Meningococcal B						
Other							

To the best of my knowledge, this person has received the above-indicated immunizations on the above dates.

Physician, Nurse, Local/State Health:	Title:	Date:
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If additional doses are added after initial signature, please initial dose and sign below.

Update signature #1:

Physician, Nurse, Local/State Health:	Title:	Date:
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Update signature #2:

Physician, Nurse, Local/State Health:	Title:	Date:
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My child has not met the minimum requirements for his/her age. I agree to resume immunizations within 30 days from the date I was notified (today's date noted below) and to submit a signed Certificate of Immunization.

Parent/Guardian Signature:	Date:
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Statement of Exemption to Immunization Law

In the event of an outbreak, exempted persons may be subject to exclusion from school or childcare facility.

Medical (Med) Exemption: (Indicate vaccine above, requires physician signature) The physical condition of the above-named person is such that immunization would endanger life or health or is medically contraindicated due to other medical conditions.

History of Disease (HD) Exemption: (Indicate vaccine above, requires physician signature) To the best of my knowledge, the above named person has had prior infection as indicated by prior diagnosis or laboratory confirmation.

Physician Signature:	Date:
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Religious (Rel), Philosophical/Moral (PBE) Exemption: (Indicate vaccine above, requires parental signature)

Parent/Guardian Signature:	Date:
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* Medical =Med, History of Disease = HD, Religious = Rel, Philosophical/Moral = PBE